

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01688

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cabot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Wilson</u> First <u>Chase</u> Middle <u>Jr</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1962</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15, 1961</u>					
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MD</u>					
13. FATHER'S NAME <u>Wilson Chase</u>				14. MOTHER'S MAIDEN NAME <u>Rosemarie Jackson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes give war or dates of service) _____				16. SOCIAL SECURITY NO. _____							
17. INFORMANT <u>Rosemarie Chase Sunderland</u> Address _____				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory infection</u> 527 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>H. W. Wood</u> M.D.				DATE SIGNED <u>2/23/62</u>							
EXAMINER'S NAME (Type) _____				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Patuxent Church Cem.</u>		22d. LOCATION (City, town, or country) <u>Huntingtown, Md.</u> (State) _____					
23. FUNERAL DIRECTOR <u>Rever E. Perry</u> Address <u>Huntingtown, Md.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE _____					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01706

01689

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>T.</u> Middle <u>NEWTON</u> Last <u>GIBSON, SR.</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1874</u>	
				9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner (Retired) Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cabaret Co., Ind</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Shuckles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>James Gibson - Huntingtown, Ind</u>				18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. J. Weems</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>				22d. ADDRESS <u>HUNTINGTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 11, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Methodist</u>		23d. LOCATION (City, town, or county) <u>Cabaret County Ind</u> (State) <u>Ind</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Harkness & Son - Mutual, Ind.</u>				25a. REC'D BY REGISTRAR <u>FEB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur D. Harkness</u>	

TO HOSPITAL 22. ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01707

CERTIFICATE OF DEATH

01690

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby Prince Frederick c. LENGTH OF STAY IN 1b X Lusby d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lusby d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Joseph Goff				4. DATE OF DEATH Month February Day 20 Year 1962													
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1888		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driving				10b. KIND OF BUSINESS OR INDUSTRY Trucking				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Henry Goff				14. MOTHER'S MAIDEN NAME Rachel Holly													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-B-1585				17. INFORMANT Annie Goff, Lusby, Md.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral Hemorrhage Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Lusby		(County) Calvert		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 4/19 19 62 to 2/20 19 62 and that death occurred at 8:30 M, from the causes and on the date stated above.																	
22a. SIGNATURE Robert de Villarreal				22b. DATE 2/20/62				22c. PHYSICIAN'S NAME (Type) Robert de Villarreal				22d. ADDRESS St. Leonard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 2-25-62				23c. NAME OF CEMETERY OR CREMATORY Zion Hill Church				23d. LOCATION (City, town, or county) Lusby, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Leroy E. Berry				24a. ADDRESS Huntington, Md.				25a. REC'D BY REGISTRAR 27				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01708

CERTIFICATE OF DEATH

01691

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 6 wks.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Leonard		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith S. Middle Phillips Last —		4. DATE OF DEATH Month February Day 12 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/92
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winfield Scott		14. MOTHER'S MAIDEN NAME Anne Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Howard E. Phillips		Address St. Leonard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH 5 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 25 , 19 62 to Feb 12 , 19 62 , that (I) (we) last saw the deceased alive on Feb 12 , 19 62 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE R. G. McClarrick		22b. DATE SIGNED 2/15/62	
22c. PHYSICIAN'S NAME (Type) R. G. McClarrick		22d. ADDRESS St. Leonard	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Feb. 15, 1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Nelsonville, Athens Co., Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE A. G. Harkness for, Mutual, Md.		25a. REC'D BY REGISTRAR DATE FEB 15 '62	
25b. REGISTRAR'S SIGNATURE William S. Harkness			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01709

01692

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie Middle Reid Last Reid				4. DATE OF DEATH Month Feb. Day 9 Year 1962			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 12		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Naryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jessie Reid				14. MOTHER'S MAIDEN NAME Elizabeth Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Lydia Reid - Huntingtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-10 19 62 to 8 Feb 19 61 , that (I) (we) last saw the deceased alive on Feb 8 19 62 , and that death occurred at 12 M, from the causes and on the date stated above.							
22a. SIGNATURE George J. Weems				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George J. Weems				22d. ADDRESS Huntingtown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-11-62		23c. NAME OF CEMETERY OR CREMATORY Plum Point		23d. LOCATION (City, town, or county) (State) Calvert Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Linkney E. Sewell, Prince Fred				25a. REC'D BY REGISTRAR DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE Linkney E. Sewell	

TO HOSPITAL) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01710 CERTIFICATE OF DEATH 01693

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PR. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills 1617-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Nursing Home		d. STREET ADDRESS 6402- PORTAL Ave SE	
3. NAME OF DECEASED (Type or print) First CORNELIA Middle F. Last RUFFNER		4. DATE OF DEATH Month Feb. Day 6 Year 19 62	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 14-1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Smith		14. MOTHER'S MAIDEN NAME Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT James R. Ruffner		Address 6402- Portal Ave SE Wash 22 DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 26 19 62 to Feb. 5 19 62 that (I) (we) last saw the deceased alive on Feb. 5 19 62 , and that death occurred at 10:15 a from the causes and on the date stated above.			
22a. SIGNATURE Page C. Jett		22b. DATE SIGNED 2-6-62	
22c. PHYSICIAN'S NAME (Type) Page C. Jett		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9-62	
23c. NAME OF CEMETERY OR CREMATORY Valley View Cem.		23d. LOCATION (City, town, or county) (State) Wokeville Va	
24. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.		25a. REC'D BY REGISTRAR DATA 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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